

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04094

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH:
County Hanford

City or town Hanover Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME
Harry Joseph Bonell

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Nellie Hanford Bonell

7. Birth date of deceased (mo., day, yr.) May 28 - 1906 6. (c) If alive, give age 41 years

8. AGE: Years 40 Months 11 Days 21 If less than one day

9. Birthplace Hanover Grace
(Town, county, and state)

10. Usual occupation Club

11. Industry or business -

MOTHER FATHER 12. Name Harry J. Bonell

13. Birthplace Wilmington Del.

14. Maiden name Margaret C. Dugift

15. Birthplace Hanover Grace

16. Informant Nellie H. Bonell (wife)

Address 803 Green

17. Burial At Sea Date thereof 5/22/47
(Burial, cremation, or removal. Which?)

Cemetery or crematory At Sea

Location Hanover Grace

18. Funeral director Pennington & Son

Address Hanover Grace

19. May 27 1947 a. t. lewis
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Hanford

City or town Hanover Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No. 533 Green
(If rural, give LOCATION)

2. (a) If veteran, name war -

3. (b) Social Security Number -

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947 at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 10 1946 to May 19 1947

and that I last saw him alive on May 19 1947

Immediate cause of death Pulmonary Tuberculosis

Due to Cachexia

Due to Cachexia

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE Charles J. Foley M.D. M. D. or other -

Address Pennington & Son Date signed May 27 1947

RECEIVED

MAY 26 1947

BUREAU F B I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

0409580
Reg. Dist. No.

1. PLACE OF DEATH:

County Harford Co.City or town Abingdon (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas Braxton, Jr.4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single6. (c) If alive, give age 81 years7. Birth date of deceased (mo. day, yr.) July 11, 19008. AGE: Years 46 Months 10 Days 2 If less than one day 16 hrs. 45 min.9. Birthplace Bay View, Baltimore Co. Maryland (Town, county, and state)10. Usual occupation Farmer11. Industry or business none12. Name Thomas Braxton13. Birthplace King Williams Co. Va.14. Maiden name Keyziah Fountain15. Birthplace Churchton A.A. Co. Md.16. Informant Keyziah BraxtonAddress Abingdon Md.17. Burial Burial Date thereof 5/16/47 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory John Wesley CemeteryLocation Abingdon Md.18. Funeral director Harford C. McCormackAddress Abingdon Md.19. Date rec'd by registrar May 16, 1947 Name M. M. Mansdale Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Abingdon (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

218-01-7580

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1321. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-8-41 to 5-13 1947.and that I last saw him alive on 5-13 1947.Immediate cause of death Chronic Glomerulonephritis with hypertension, edema

DURATION

7 yrs

Due to...

Due to...

Other conditions none

11 days

(Include pregnancy within 8 months of death)

Major findings of operations noneDate of op. none

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frederick O Hodson, M.D.

M. D. or other

Address Edgewood Md. Date signed 5-13-47

RECEIVED

MAY 20 1947

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830a

04096

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County

1. *Harford*

City or town

Rural - Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

30 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Catherine Jane Brown

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

John Brown

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

September 14, 1873

8. AGE:

Years Months Days If less than one day

74 8

hrs. min.

9. Birthplace

Pennsylvania

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Unknown

MOTHER

12. Name

Unknown

13. Birthplace

Loret, Pa.

14. Maiden name

Catherine J. Wilson

15. Birthplace

Unknown

16. Informant

John R. Brown

Address

Joppa, Md.

17. Burial

Date thereof May 17, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Paul Lutheran

Location

Near Aberdeen

18. Funeral director

Henry Tarrington & Sons

Address

Aberdeen, Md.

19. May 16 1947

(Date rec'd by registrar)

Nellie R. Riley

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Redland - Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No. Ste. 600 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14th 1947 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to May 14 1947

and that I last saw her alive on May 12 1947

Immediate cause of death Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

GB Jonathan, M.D. M. D. or other

Address Aberdeen, Md. Date signed 5/16/47

RECEIVED

MAY 21 1947

BUREAU F B I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

04697

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH:

County Harford County
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Harford Memorial HospitalHow long in hospital or institution? 50 mins.

3. (a) FULL NAME

Clarence Brown

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 2nd, 1869 6. (c) Native, give age years8. AGE: Years 78 Months 1 Days 4 If less than one day hrs. min.9. Birthplace Brooklyn, New York
Town, county, and state10. Usual occupation Retired Salesman

11. Industry or business

12. Name Simon S. Brown13. Birthplace New York14. Maiden name Jessie Hegeleman15. Birthplace New York16. Informant Herbert W. BrownAddress 71 Jefferson Blvd, Staten Island, N.Y.17. Burial, cremation, or removal, Which? Burial Date thereof May 9, 1947 (month) (day) (year)Cemetery or crematory CokesburyLocation Abingdon Md18. Funeral director Howard E. McCormickAddress Abingdon Md19. Date rec'd by registrar May 12, 1947 A. L. Lewis, M.D. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Beloir (If outside city or town limits, write RURAL and give nearest town)Street No. 106. E. Gordon St. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6th 1947 at 6:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6th 1947 to same 1947, and that I last saw him alive on same 1947.Immediate cause of death Coronary occlusionDue to —Due to —Other conditions Cataract (left eye)
Cryptorchidia (right)
Include pregnancy within 3 months of death.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work? —

23. SIGNATURE

John F. Noguera MD. John F. Noguera MD for other
Address Harford Mem Hosp Date signed 5/6/47

RECEIVED

MAY 14 1947

BUREAU F.B.I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04098
181

CERTIFICATE OF DEATH

93c
Reg. Dist. No.

1. PLACE OF DEATH:

Harford
Bel Air Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Richard Herbert Cullum

4. Sex

5. Color or race

6. (d) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband-as wife

Josie Thompson

6. (c) If alive, give age 65 years

7. Birth date of deceased (mo. day. yr.)

April 15 - 1883

8. AGE:

Years

Months

Days

If less than one day

64

hrs.

min.

9. Birthplace

Creswell Harford Co. Md

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

12. Name

William Cullum

13. Birthplace

Harford Co

14. Maiden name

Martha J Cullum

15. Birthplace

Harford Co Md

16. Informant

Mrs. Richard H. Cullum

Address

Bel Air Md B-FF

17. Burial

Date thereof May 18 - 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Calvary

Location

Near Creswell Harford Co

18. Funeral director

Henry Young Sons

Address

Cherden Md

19. May 12 47

19. (Date rec'd by registrar)

Nellie H. Riley

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Creswell (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

World

3. (b) Social Security Number

212-14-3052

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1947 at 6:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46, to May 9 1947 and that I last saw her alive on May 9 1947

Immediate cause of death

acute pulmonary edema

DURATION

15 mins

Due to. *Pathomictic cardio vascular disease*

2 yrs

Due to.

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

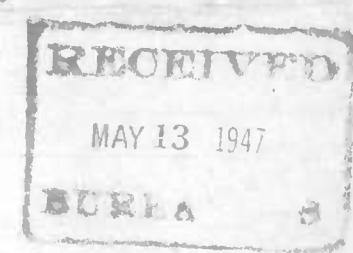
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Ralph Horlyk
Chambley May 10
M. D. or other
Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly. This is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04099

CERTIFICATE OF DEATH

Reg. Dist. No. 185

159

1. PLACE OF DEATH:

County Harford
 City or town Hanover Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

3. (a) FULL NAME

Baby Boy Dubin

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

—

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

May 26th 47 at 3:45 PM

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
—	—	—	9 hrs. 30 min.

9. Birthplace

Harford Memorial Hosp.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

12. Name Florence Edwin Dubin

13. Birthplace

New York

14. Maiden name

Florence Newman

15. Birthplace

New York City

16. Informant

Hospital Records

Address

Hanover Grace

17. Burial

Date thereof 5/28/47
 (Burial, cremation, or removal. Which?)

Cemetery or crematory

Mount Hebron

Location

Brooklyn N. Y.

Burial

Pennsylvanian

Funeral director

Hanover Grace

Address

Hanover Grace

19. Date rec'd by registrar

May 27 18 47 G. L. Lewis M.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Hanover Grace
 (If outside city or town limits, write RURAL and give nearest town)Street No. Hospital Hanover Grace
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 27th 19 47 at 1 PM

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

May 26th 19 47 to May 27th 19 47and that I last saw him alive on May 26th 19 47

Immediate cause of death

Respiratory and Circulatory failure

Due to

Prematurity (6 mos. of fetal life)

Due to

Respiratory and Circulatory failure

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Noguera MD

M. D. or other

Address Harford Memorial Hosp Date signed 5/27/47

RECEIVED

MAY 30 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-2

CERTIFICATE OF DEATH

04100

Reg. Dist. No. 185

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital
3 Days

How long in hospital or institution?

3. (a) FULL NAME

Alice M. Duff

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife.....

Daniel J. Duff

6. (c) If alive, give age.....years

7. Birth date of deceased (mo. day, yr.)

April 23, 1879

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Harford Co., Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

George Dennis

12. Name.....

Harford Co., Md.

13. Birthplace.....

Alice Mitchell

14. Maiden name.....

Harford Co., Md.

15. Birthplace.....

Mr. Kendall Duff

16. Informant.....

Aberdeen, Md. P.D. #2

Address.....

Burial

Date thereof.....

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Rock Run

Location.....

Near Darlington, Md.

18. Funeral director.....

Henry Tarrington & Sons

Address.....

Aberdeen, Md.

19. Date rec'd by registrar.....

May 26, 1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 24th 1947, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 28 1946 to May 24 1947

and that I last saw her alive on May 24 1947

IMMEDIATE CAUSE OF DEATH.....

Chronic Nephritis

DURATION.....

Due to arteriosclerotic Cardio-Vascular disease

Due to.....

OTHER CONDITIONS.....

(Include pregnancy within 3 months of death)

MAJOR FINDINGS OF OPERATIONS.....

None Date of op.....

AUTOPSY RESULTS.....

None PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

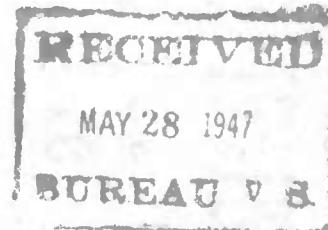
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

J. H. Ramsey, M.D. M. D. or other

Address..... Aberdeen, Md. Date signed 5/24/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04101

181

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Harford
County Rural BellairCity or town 5 weeks
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?
Hospital, institution, or street address where death occurred:Harford Nursing Home
5 weeks

How long in hospital or institution?

3. (a) FULL NAME JENNIE F. FORD4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife John Wm. Ford7. Birth date of deceased (mo., day, yr.) June 25, 1879 8. (c) If alive, give age 70 years8. AGE: 67 Years 11 Months 3 Days If less than one day — hrs. — min.9. Birthplace N. Y. (Town, county, and state)10. Usual occupation House Duties11. Industry or business Retired12. Name Fred. W. Wells13. Birthplace N. Y.14. Maiden name Ida Sarah Griffin15. Birthplace N. Y.16. Informant Thos. Myrtle HeinesAddress Harford Grace, Md.17. Burial Arlington Meth. Cem. Date thereof May 31, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Harford Co. Md.Location Robert A. Bartholomew18. Funeral director R. Madison MitchellAddress Harford Grace, Md.19. Date record by registrar May 30, 1947 Bethel B. Bright
(Date record by registrar) Deputy Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State Md. County HarfordCity or town Harford Grace (If outside city or town limits, write RURAL and give nearest town)Street No. 45-3 Green St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number —

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 28, 1947 at 11 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 28, 1947 to MAY 28, 1947 and that I last saw h. ER alive on MAY 28, 1947.Immediate cause of death CEREBRAL HEMORRHAGE

DURATION

6 HoursDue to PROB. HYPERTENSION AND
ARTERIOSCLEROSIS.

?

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations NONE

Date of op.

Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

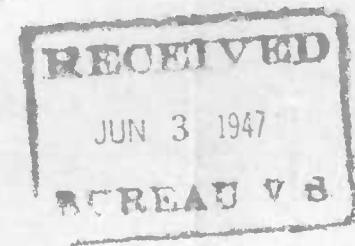
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Robert A. Bartholomew M. D. or otherAddress Forest Hill, Md. Date signed 5/28/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04102

CERTIFICATE OF DEATH

180
Reg. Dist. No.

181

1. PLACE OF DEATH:

County..... **HARFORD**
City or town..... **ABERDEEN - RURAL**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **14 yrs.**

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

HAIG**GALAJIKIAN Jr.**

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

September 16, 1932

8. AGE:

Years

Months

Days

If less than one day

14**8**

.... hrs. min.

9. Birthplace.....

Baltimore Md.
(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

MOTHER FATHER

12. Name..... **Taig Galajikian**

13. Birthplace

13. Birthplace..... **Constantinople**

14. Maiden name

14. Maiden name..... **Martha Jay**

15. Birthplace

15. Birthplace..... **Hanford Co. Md.**

16. Informant

16. Informant..... **Henriketta D. Jay**

Address

17. Burial

Date thereof..... **May 17, 1947**

(Burial, cremation, or removal. Which?)

Cemetery or crematory

18. Funeral director

19. Date rec'd by registrar

20. Address

21. Date rec'd by registrar

22. Address

23. Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Md.**County..... **HARFORD**City or town..... **ABERDEEN - RURAL**

(If outside city or town limits, write RURAL and give nearest town)

Street No..... **ROUTE # 40**

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **MAY 15**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

Partial Carbonization

DURATION

Due to..... **Comflagration**

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

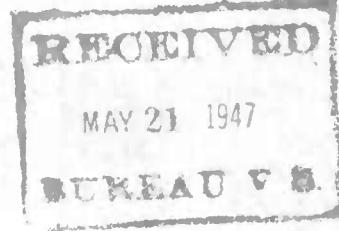
Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... **ACCIDENT** Date of **5/15/47**Where did injury occur?..... **NEAR ABERDEEN HARFORD MD** (City or town) (County) (State)Injured at home, farm, industry, public place (where?)..... **HOME**Means of injury..... **Fire in Home** Injured at work?.....23. SIGNATURE..... **John Lawrence M.D.** M.D. or otherAddress..... **Aberdeen, Md.** Date signed..... **5/15/47**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. It is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 183

4511

1. PLACE OF DEATH:

County

Hagerstown

City or town White Hall P. T. D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harrine M. Gammill

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 6-1886

6. (c) If alive, give age years

8. AGE: Year Months Days If less than one day

61 1 6 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Dress Makers

11. Industry or business

12. Name

William E. Gammill

13. Birthplace

Pa.

14. Maiden name

Elizabeth Ann Campbell

15. Birthplace

Pa.

16. Informant

Miss Harrine Gammill

Address

White Hall, Md.

17. Burial

Date thereof May 18-1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Harrington

Location

Harrington, Md.

18. Funeral director

Howard S. Marklin

Address

White Hall, Md.

19. Date rec'd by registrar

May 15 1947 Thomas R. Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. Hagerstown

County

Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural - Black House, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-12-2528

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947 at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 12 1947 to May 12 1947

and that I last saw him alive on May 10 1947

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

P. M. France M. D. or other

Address Parkton, Md. Date signed 5/14/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

516

04103
185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Harford County

City or town

Harbor de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Harford Memorial Hospital -

How long in hospital or institution? 20 days

3. (a) FULL NAME

Mr. ^{James} Carroll Hanna

4. Sex

M.

5. Color or race

Wh.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 27, 1877

8. AGE:

Years
69Months
10

Days

If less than one day

hrs.

min.

9. Birthplace

Harford County, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name..... John C. Hanna

13. Birthplace..... Md.

14. Maiden name..... Priscilla Kean

15. Birthplace..... Md.

16. Informant..... Edgar Durham

Address..... Bel Air, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... May 30/47
(month) (day) (year)

Cemetery or crematory..... St. Ignatius

Location..... Hickory Mt.

Dean & Foster

18. Funeral director.....

Address..... Bel Air, Md.

19. Date rec'd by registrar.....

(Date rec'd by registrar)

May 27, 1947 A. L. Jensen, M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Harford

City or town..... Monkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May, 26th 1947, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

19.

and that I last saw him alive on May 26th 1947

19.

Immediate cause of death

Cachexia and heart failure

DURATION

Due to..... Carcinoma of Prostate

unknown

Due to.....

Other conditions..... Metastasis to 2ndLumbar Vertebra and pelvic
(Include pregnancy within 3 months of death)
carcinomatosis

Major findings of operations.....

None

Date of op.

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

John F. Noguera MD

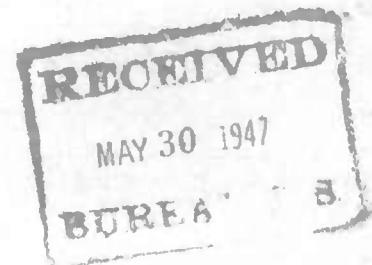
M. D. or other

Address.....

Harford Mem. Hospital

Date signed

5/26/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

18602

041014

CERTIFICATE OF DEATH

Reg. Dist. No. 18602

1. PLACE OF DEATH:

County Harford
City or town Bell Air
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrsHospital, institution, or street address where death occurred: Fountain Green HospitalHow long in hospital or institution? 2 yrs

3. (a) FULL NAME

William Sherman Hudson

3. (b) Social Security Number

4. Sex Male 5. Color or race wh 6. (a) Single, married, widowed, or divorced Widowed8. (b) Name of husband or wife Alma Rost Hudson7. Birth date of deceased (mo., day, yr.) April 26, 1868 6. (c) If alive, give age years8. AGE: Years 81 Months - Days 26 If less than one day hrs. min.9. Birthplace Alleghany co. N.C.
(Town, county, and state)10. Usual occupation Farming

11. Industry or business

MOTHER FATHER
12. Name Joseph Hudson
13. Birthplace England Virginia
14. Maiden name Nancy Nash
15. Birthplace Ashley Co. N.C.16. Informant Willard P. HudsonAddress Forest Hill Md17. Burial Date thereof May 24-1947
(Burial, cremation, or removal. Which?) Burial (month) (day) (year)Cemetery or crematory Mt. ZionLocation Fountain Green Md.18. Funeral director Clarence E. ArthurAddress York Md.19. 5/23 1947 Biella Towood
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State N.C. County Alleghany
City or town Rural - Sparta
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947 at 8:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945 to May 22 1947and that I last saw him alive on May 22 1947

Immediate cause of death

Septic pneumonia DURATION 6 daDue to Fractured hip 10 wks.

Due to...

Other conditions arteriosclerotic hypertension 7 yrs.Cardiovascular disease 2 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Fall Date of May 22, 1947Where did injury occur? Bell Air Harford Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Fountain Green Hosp.Means of injury Fall Injured at work? _____23. SIGNATURE Willard P. Hudson M. D. or otherAddress Forest Hill Md Date signed 5/22/47

RECEIVED
MAY 27 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

04105

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County Hanford
 City or town Hanford, Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 yrs.
 Hospital, institution, street address where death occurred
St. Francis Villa
 How long in hospital or institution? 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Hanford
 City or town Hanford, Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Market & Commerce
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME Rector Mary Catherine (Anna Kennedy) 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife —

7. Birth date of deceased (mo., day, yr.) November 24, 1899 6. (c) If alive, give age — years

8. AGE: Years 47 Months 5 Days 10 If less than one day — hrs. — min.

9. Birthplace Wilmington Del. (Town, county, and state)

10. Usual occupation Retired Teacher

11. Industry or business —

FATHER 12. Name David Kennedy

MOTHER 13. Birthplace Wilmington Del.

14. Maiden name Rebecca Jaggard

15. Birthplace Wilmington Del.

16. Informant acob. Records

Address Market & Commerce Bld.

Burial Cathedral Date thereof 5/7/47

(Burial, cremation, or removal. Which?)

Cemetery or crematory —

Location Wilmington Del.

18. Funeral director Wilmington & Son

Address Hanford, Grace, Md.

19. Date rec'd by registrar May 6 1947

(Date rec'd by registrar) A. L. Lewis, M.D.

Registrar —

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1947 to May 4 1947 and that I last saw her alive on May 4 1947

Immediate cause of death Arteria Polonica DURATION Cerebral Hemorrhage

Due to —

Due to —

Other conditions Toxemia (Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

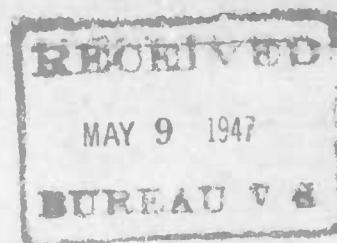
Where did injury occur? — (City or town) — (County) — (State) —

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Charles J. Foley Jr. M.D. M. D. or other —

Address — Date signed May 6 1947



MARYLAND STATE DEPARTMENT OF HEALTH X

2411 N. Charles St., Baltimore

46d

CERTIFICATE OF DEATH

04106
182

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Harford

City or town..... Cardiff

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Benjamin Lloyd

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife..... Sarah E. Lloyd

7. Birth date of deceased (mo. day, yr.) Feb. 21, 1882

6.(c) If alive, give age 61 years

8. AGE: Years	Months	Days	If less than one day
65	2	24	hrs. min.

9. Birthplace..... Harford Co. Md.

(Town, county, and state)

10. Usual occupation..... Plasterer

11. Industry or business

12. Name..... Robert W. Lloyd

13. Birthplace..... Wales

14. Maiden name..... Mary Davis

15. Birthplace..... Wales

16. Informant..... Mrs. Sarah Lloyd

Address..... Cardiff, Md.

17. Burial..... Date thereof..... May 18, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Slate Ridge cemetery

Location..... Delta, Pa.

18. Funeral director..... Hubert P. Harkins

Address..... Delta, Pa.

19. Date rec'd by registrar..... May 17, 1947 M. O. Kirk

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford

City or town..... Cardiff

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION A

20. DATE OF DEATH..... May 15 1947 at 10.40

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 15 1947 and that I last saw her alive on May 15 1947

Immediate cause of death.....

intestinal obstruction

Due to..... carcinoma of the large bowels

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Bayon Done

M.D. or other

Address..... CARDIFF Date signed..... 5-16-47

RECEIVED

JUN 24 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 183

4512

1. PLACE OF DEATH:

County

City or town

Hobson
Monsville

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

York Co Pa

(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

Dry Cleaning

12. Name

MOTHER

FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date

regd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Monsville Md

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 17,

19 47

at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 13, 19 47 to May 17, 19 47

and that I last saw him alive on May 16, 19 47.

Immediate cause of death

Internal Hemorrhage
from Primary Cancer of ColonDue to Liver & Metastasis
to Colon.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Norman H. Gemmill M.D. M.D. or other

Address Stewartstown Pa. Date signed 5/17/47.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04107

CERTIFICATE OF DEATH

Reg. Date. No. 185

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 yrs.

Hospital, institution, or street address where death occurred:

St. Francis Villa

How long in hospital or institution?

5 yrs.

3. (a) FULL NAME

Sister M. Nunzio (Mary Ann Conway)

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8/8/1872

6. (c) If alive, give age

year

8. AGE: Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

John Conway

12. Name

MOTHER FATHER

John Conway

13. Birthplace

Ireland

14. Maiden name

Anne Ward

15. Birthplace

Ireland

16. Informant

Hospital Records

Address

Home de Grace

17. Burial

Date thereof 5/10/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Francis Villa

Location

New Wilmington Del.

18. Funeral director

Hannington & Son

Address

Home de Grace, Md.

19. Date rec'd by registrar

May 9 1947

(Date rec'd by registrar)

A. Y. Lewis M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Home de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. Market & Commerce

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 1947 to May 7 1947

and that I last saw deceased alive on May 7 1947

Immediate cause of death

Gastric Distension

Inflammation

Due to

Hepatitis

Cerebral Hemorrhage

Due to

Other conditions

John Conway

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Charles Foley, M.D. or other

Address Home de Grace, Md. Date signed

RECEIVED

MAY 13 1947

5 11 1 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04108

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Blanche E Poulton

5. Color of race

6. (a) Single, married, widowed, etc.

Female White Single

Mother

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Dec. 16 1872

8. AGE:

Years

Months

Days

If less than one day

75 6 hrs. min.

9. Birthplace

Baltimore Md.

(Town, County, and state)

10. Usual occupation

Seamstress

11. Industry or business

Sewing Factory

FATHER

12. Name

John P. Poulton

13. Birthplace

Baltimore Md.

MOTHER

14. Maiden name

Catherine Hargrave

15. Birthplace

Baltimore Md.

16. Informant

Mrs. Catherine W. Miller

Address

Fallston, Md.

17. Burial, cremation, or removal (Which?)

Date thereof May 24/47

(month) (day) (year)

Cemetery or crematory

Forest Hill

Location

Forest Md.

18. Funeral director

A. D. Bailey

Address

Baltimore Md.

19. (Date rec'd by registrar)

5/24 1947

Burial or removal

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

Rural

Forest Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 22 1947 at 5⁰⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 1947 to May 22 1947

and that I last saw her alive on May 22 1947

Immediate cause of death

CEREBRAL HEMORRHAGE

DURATION

8 da.

Due to ESSENTIAL HYPERTENSION

?

Due to

Other conditions GENARTERIOSCHEROSIS

?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson

M. D. or other

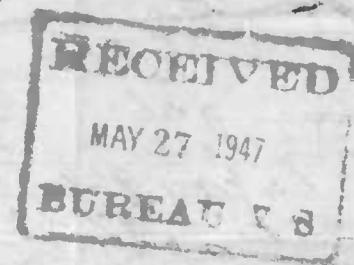
Address

Forest Hill Md.

Date signed

5/22/47

POULTON
FRIEZE



Evidence for the change
of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04109

93d

FILM NO. G 110 JUL 1- 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County

Harford

City or town

Rural - Bel Air

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Harford convalescent Home

2 mos.

How long in hospital or institution?

3. (a) FULL NAME

CORA

SCARBOROUGH

3. (b) Social Security Number

4. Sex

5. Color or race

6. Grade, married, widowed, or divorced

6. (b) Name of husband

Male White Widower

Howard Scarborough

7. Birth date of

deceased (mo., day, yr.)

Reg Jan. 30 1877

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

70

115

3 26

hrs.

min.

9. Birthplace

Harford Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At home

12. Name

Edgar P. Hudson

13. Birthplace

Harford Co. Md.

14. Maiden name

Sarah England

15. Birthplace

Harford Co. Md.

16. Informant

James Edward Hulley

Address

10th Street, Md.

17. Burial

Date thereof (month) (day) (year)

Cemetery or crematory

Ascension Cem.

Location

Harford Co. Md.

18. Funeral director

J. F. Bailey

Address

Darlington, Md.

19. (Date paid by registrar)

May 27, 1947

Registrar

(Date paid by registrar)

May 27, 1947

Address

Forest Hill, Md.

(Date signed)

5/26/47

Date signed

5/26/47

M. D. or other

W. P. Hudson

Address

Forest Hill, Md.

Date signed

5/26/47

Reg. Dist. No.

182

4109

04109

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

182

RECEIVED

JUN 24 1947

BUCKEY CO.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93a

04110

Reg. Diat. No. 185

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County

Harford

City or town

Hardey Grace

(If outside city or town limits, write RURAL and give nearest town)

- 2 yrs.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alice Etta Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Negro

Married

6. (b) Name of husband or wife

Thomas F. Smith

7. Birth date of deceased (mo., day, yr.)

2/16/1894

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

hrs. min.

9. Birthplace

Talbot Co.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

-

12. Name

George F. Henry

MOTHER FATHER

Worcester Co.

13. Birthplace

Alice Ridenout

14. Maiden name

Bogman, Talbot Co.

15. Birthplace

Thomas F. Smith (husband)

16. Informant

Stokes & Friend

Address

Business

Date thereof
(month) (day) (year)

17. (Burial, cremation, or removal, Which?)

Burial

Cemetery or crematory

Carlton

Location

Baltimore

18. Funeral director

Charles Cooper

Address

510 Carlton Ave., Balt. Md.

19. (Date rec'd by registrar)

May 7 1947

O. L. Lewis, M. D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

Maryland

County

Harford

City or town

Hardey Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No

Stokes & Friend

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 7 1947 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 4 1947 to May 7 1947

and that I last saw h. alive on

19 1947

Immediate cause of death

Anemia, myocarditis

DURATION

Due to

Pulmonary Occlusion

Due to

Cardiac Failure

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

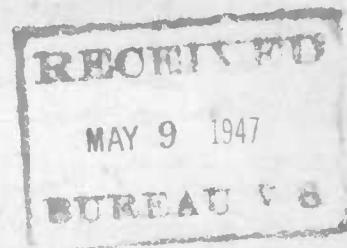
23. SIGNATURE

M. D. or other

Address

I. Hardey Grace

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04111

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

M
I
VS A15 9-45-15
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Physicians: please write the causes of death clearly and legibly. is especially important.

1. PLACE OF DEATH:
County..... Hanford
City or town..... Hanover de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred: Hanford Memorial Hospital
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Md. County..... Hanford
City or town..... Hanover de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 815 Otago St.
(If rural, give LOCATION)

3. (a) FULL NAME William St. max

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Marr.

6. (b) Name of husband or wife Mrs. Anna St. max

7. Birth date of deceased (mo., day, yr.) 9-5-1884 6. (c) If alive, give age 39 years

8. AGE: Years 62 Months 8 Days 4 If less than one day hrs. min.

9. Birthplace Caroline Co., Md. (Town, county, and state)
Mother. Laborer.

10. Usual occupation Md. State Road

11. Industry or business O. S. S. Co. St. max

MOTHER FATHER 12. Name..... unknown

13. Birthplace unknown

14. Maiden name..... unknown

15. Birthplace unknown

16. Informant..... Anna St. max

Address 815 Otago St., Hanover, Md.

17. Burial Date thereof May 13, 1947 (month) (day) (year)
(Burial, cremation, or removal. Which?) Cemetery or crematory Ashbury

Location Perryville, Md. Rural

18. Funeral director Lee A. Patterson & Son

Address Perryville, Md.

19. Date rec'd by registrar May 12, 1947 (Date rec'd by registrar) W. L. Leidson, Registrar

MEDICAL CERTIFICATION	
2D. DATE OF DEATH	May 9 th 47 at 11 ⁴⁵ M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 st to May 9 th 47, and that I last saw him alive on May 9 th 47.	
Immediate cause of death. Congestive heart failure	
Due to. Recurrent cerebral thromboses	
Due to.	
Other conditions.	

(Include pregnancy within 3 months of death)
Major findings of operations. none Date of op.

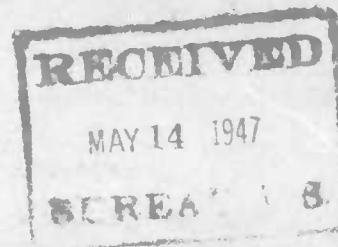
Autopsy results. no PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE John F. Noguera M.D. or other
Address Hanford Mem Hosp Date signed 5/10/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct, give is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e

04112

185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County HarfordCity or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 hrs.Hospital, institution, or street address where death occurred: Harford Memorial HospitalHow long in hospital or institution? 7 hrs.

3. (a) FULL NAME

Baby Boy Sumpster4. Sex M5. Color or race B6. (a) Single, married, widowed, or divorced Infant

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

May 16, 1947

8. AGE: Years

Months

Days

If less than one day

6 hrs. 55 min.9. Birthplace: Havre de Grace, Harford, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Fortune Sumpster

13. Birthplace

14. Maiden name Mary Snell

15. Birthplace

South Carolina16. Informant Harford Memorial HospitalAddress Havre de Grace, Maryland

17. Burial

Date thereof 5-19-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. James CemeteryLocation Havre de Grace, Md.18. Funeral director Elmer E. BullockAddress 536 Lewis St. Havre de Grace, Md.19. May 18, 1947
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 516 Freedom St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 17, 1947 at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 16, 1947 to May 17, 1947and that I last saw him alive on May 17, 1947

Immediate cause of death

Patient frommen vole

Due to

Prematurity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

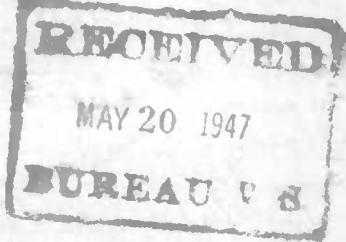
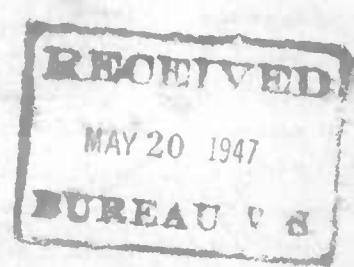
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John Wolbert M.D.
M. D. or otherAddress Havre de Grace Date signed May 18



Evidence for change of age
shown on:

MARYLAND STATE DEPARTMENT OF HEALTH X

2411 N. Charles St., Baltimore

FILE NO. G 110 MAY 12 1947

CERTIFICATE OF DEATH

468
Reg. Dist. No. 185

04113

1. PLACE OF DEATH:

County.

Harford
Harvard Grace

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

3. (a) FULL NAME

Marie Barry Wilson

3. (b) Social Security Number

4. Sex

Female | white | Married

6. (b) Name of husband or wife

Clinton G. C. Wilson

7. Birth date of deceased (mo., day, yr.)

Sept. 5, 1878

6. (c) If alive, give age 7 years

8. AGE:

Years | Months | Days | If less than one day
68 | 6 | 26 | hrs. min.

9. Birthplace

Phila. Penn.

(Town, county, and state)

10. Usual occupation

House Duties

11. Industry or business

Daniel Barry

12. Name

Penn.

Mother Father

Louisa Scherr

13. Birthplace

Penn.

Mother Father

14. Maiden name

Peni

Mother Father

15. Birthplace

Peni

Mother Father

16. Informant

Clinton G. C. Wilson

Mother Father

Address

Harford Grace, Md.

Mother Father

17. Burial

Date thereof

(Burial, cremation, or removal. Which?)

May 4, 1947

(month) (day) (year)

Cemetery or crematory

Angel Hill

Location

Harford Grace, Md.

18. Funeral director

R. Madison Mitchell

Address

Harford Grace, Md.

19. Date rec'd by registrar

May 2, 1947

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Harford

County

City or town

Harford Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.

201 N. London Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 1, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 21, 1947, to May 1, 1947

and that I last saw her alive on May 1, 1947

Immediate cause of death

Tuberculosis

Due to

Carcinoma of Liver

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John J. Murphy M. D. or other

Address

Harford Grace Date signed 5-2-47

RECEIVED

MAY 6 1947

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please, write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04114

191

CERTIFICATE OF DEATH

Reg. Dist. No.

94a
CB

1. PLACE OF DEATH:

County

City or town

Waverley

Oberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 day

Hospital, institution, or street address where death occurred:

Post Road

How long in hospital or institution?

3. (a) FULL NAME

Josephine Boris Zeldis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Caucasian

Married

6. (b) Name of husband or wife

Elizabeth Zeldis

6. (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.)

9-28-1879

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual occupation

Machine Engineer

11. Industry or business

Ladies Wear

12. Name

Boris Zeldis

13. Birthplace

Odessa - Russia

14. Maiden name

Sarah Baronoff

15. Birthplace

Odessa - Russia

16. Informant

John D. Thompson

Address

Hotel Northern

17. (Burial, cremation, or removal. Which?)

Removal Date thereof May 18 1947

(month) (day) (year)

Cemetery or crematory

Philadelphia

Location

Ghila - Germany

18. Funeral director

Henry Taxman & Sons

Address

Oberdeen, Md.

19. (Date rec'd by registrar)

May 18 1947

Nellie H. Wiley

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Pennsylvania

City or town

Philadelphia

Street No.

1200 Linden St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

091-05-1030

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 18

1947 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from dead on arrival to

and that I last saw him alive on

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. P. Thompson

M. D. or other

Address

Aberdeen, Md.

Date signed May 18 1947

